Supplemental Forms
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SOVA
SOUTH CAROLINA
State Office of Victim Assistance
Rooted in *justice*
Guided by *law*
Propelled by *humanity*

State Office of Victim Assistance

An Office of the Governor

Rev. 6/08

PAYMENTS AND REIMBURSEMENTS AT A GLANCE & SUPPLEMENTAL FORMS

IF: You are requesting assistance with	THEN: You will need to provide
Crime Related Medical/Dental/Optical Expenses For payments to the providers or reimbursements to victims: one or more of the following will be required for all separate crime related dates of service. **SOVA pays the outstanding balance for compensable bills not fully covered by existing medical/dental insurance. If a victim has private or public medical/dental insurance, bills must first be filed with applicable companies/carriers before submission to SOVA for possible payment/ reimbursement.**	• UB-04 Medical Claim Form (from your provider) • UB-92 Medical Claim Form (from your provider) • Health Insurance Medical Claim form (CMS-1500) (HCFA-1500) (from your provider) • Itemized bill of charges from medical provider • ADA Dental Claim Form (w/treatment plan) (certificate of medical necessity might be required) • Itemized bill from vision center for eyeglasses • EOB (Explanation of Benefit from Health/Dental insurance company)(Health/Dental/Medicaid must be filed first if a victim has private or public insur ance) When the victim has Health/Dental/Medicaid Insurance coverage, he/she will have to provide information for all crime related dates of service.
Crime Related Counseling Expenses SOVA provides reimbursement for trauma (generally considered as a medical expense) only when such service is rendered by a professional who is licensed in a specialty which includes mental health counseling; this includes LMSW (when not practicing independently) LPC, LMFT, LCSW, LISW, and MD. For payments to the provider or reimbursements to victims: one or more of the following will be required for all separate crime related dates of service.	• SOVA Mental Health Counselor's Report • Itemized Statement of Charges w/CPT codes, or • Health Insurance Claim Form (CMS/HCFA-1500), (Providers can fax a copy to SOVA) • EOB (Explanation of Benefit from Health/Dental insurance company)(Health/Dental/Medicaid must be filed first if a victim has private or public insurance): When the victim has Health/Dental/Medicaid Insurance coverage, he/she will have to provide information for all crime related dates of service.
Crime Related Expenses for Medication For reimbursements to victims: one or more of the following will be required: **(Some victims will have to provide additional information from his/her treating physician if the medication is for a pre-existing condition.)**	• Copy of receipt from the pharmacy (*receipt must have* - patient's name, date, total charge, name of medication, RX number, name of the pharmacy & name of the doctor) or • Print out of 'patient history' from the pharmacy
Crime Related Funeral Expenses The person who is responsible for the funeral expenses incurred may file for reimbursement relating to the cost of the funeral. That will be the person(s) who signed the contract or who paid the funeral bill. **If the deceased victim was an adult, the victim's spouse may file for any compensable medical expenses that he/she may have incurred.** **If the deceased victim was a minor child, the parent may file for any compensable medical expenses he/ she may have incurred.**	• Death Certificate • Itemized bill/contract (* bill must include service provider's name and remit address)

1205 Pendleton St., Brown Building Room 401, Columbia, SC 29201 ♦ 1(800) 220-5370 or (803) 734-1900

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PAYMENTS & REIMBURSEMENTS AT A GLANCE & SUPPLEMENTAL FORMS (continued)

IF: You are requesting assistance with	THEN: You will need to provide
Crime Related Lost Wages The following 4 (four) criteria must be met: 1. **Employment:** The victim must have been employed at the time of the crime, 2. **Missed time from work:** The victim must have missed two (2) consecutive weeks (14 days) from work as a direct result of the crime, 3. **Reportable income:** Reimbursement is based on reportable income, and 4. **Disabled:** The victim must be under the care of a treating physician.	The following documents must be submitted • SOVA Employer's Report • SOVA Physician's Disability Report • Copy of your last two pay stubs (prior to the crime date).
Crime Related Lost Wages (You were **self employed** at the time of the crime) 1. **Employment:** The victim must have been employed at the time of the crime, 2. **Missed time from work:** The victim must have missed two (2) consecutive weeks (14 days) from work as a direct result of the crime, 3. **Reportable income:** Reimbursement is based on reportable income, and 4. **Disabled:** The victim must be under the care of a treating physician.	1) **Disability:** • SOVA Physician's Disability Report (will be required to establish disability and length of disability) 2) **Employment:** • One or more of the following will be required: (to establish employment) • SOVA Employer's Report, and/or • 1099, (prior year form will be used for short term reimbursements) (lost wages are calculated using information for the year of the crime) and/or • W-2 (prior year form will be used for short term reimbursements) (lost wages are calculated using information for the year of the crime). 3) **Reportable Income:** (lost wages are calculated using information for the year of the crime) • One or more of the following will be required: (to establish income/reimbursement) • 1040 US Individual Income Tax Return (prior year form will be used for short term reimbursements), • Schedule SE (Form 1040) Self – Employment Tax Form, • Form 4070 – Employee's Report of Tips to Employer.
Important Information The following are forms/documents that are **UNPROCESSABLE** and **can not** be accepted	**Unprocessable Forms** • Final Notice • Statements • Bills that are not itemized • Incomplete bills (missing information) • Cash register receipt from pharmacy • Incomplete receipt from pharmacy • Collection notices
Important Information The following is a list of some non-covered expenses	**Non-covered Expenses** • Treatment not directly related to the crime on which the claim is based • Over-the-counter items not prescribed by a treating physician • Mileage for court appearances • Hotel accommodations • Public transportation • Food items • Household items • Household utilities

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SOVA Mental Health Counselor's Report

Rev. 6/08

State Office of Victim Assistance ♦ 1205 Pendleton St., Brown Blg., Room 401, Columbia, SC 29201 ♦ Phone: (803) 734-1900 ♦ Fax: (803) 734-2261

Refer to instructions and stipulations on reverse side.

Today's Date ____/____/_____

Victim's Legal Name _____ Claimant *(if a different person)* _____

Social Security No. _____/____/_____ Crime Date ____/____/_____

Is the trauma and the treatment a direct result of this crime? **YES ____ NO ____**

Presenting Complaint _____

Diagnosis of Record _____

_____

Description of injury and/or psychological trauma as related to victimization _____

_____

_____

_____

HEALTH INSURANCE CARRIER

_____
Policy #

( )
_____
Telephone No.

_____
Company Name

_____
Mailing Address or P.O. Box

_____
City/State/Zip Code

_____ _____ ( )
_____
Authorized Signature of Treating Therapist/Counselor | Printed Name of Payee | Telephone No./Extension

_____ _____ _____
License Type and No. | Mailing Address | City/State/Zip Code

_____ _____ _____
Supervisor's Signature | License Type and No. | Date

NOTE: SOVA *does* NOT *act as guarantor for any services rendered.*

Mental Health Counseling Reimbursement

Definition

Mental health counseling for compensation purposes means "the assessment, diagnosis and treatment of an individual's mental and emotional functioning that is required to alleviate psychological trauma resulting from a compensable crime." This definition is in accordance with state statutes that afford reimbursement for medical expenses on behalf of eligible victims.

Supporting Documents Required

- Mental Health Counselor's Report form must be completed by the victim's counselor and must certify whether the psychological trauma being addressed is a direct result of the crime.
- **Itemized bill in the victim's name** from the mental health counselor detailing the actual dates of service, type provided (i.e. individual, group, medication management), the CPT code assigned, and the amount charged.

Licensed Professional

This office provides reimbursement for trauma treatment (generally considered as a medical expense) only when such service is rendered by a professional who is licensed in a specialty which includes mental health counseling; this includes medical doctors, psychiatrists, and psychologists.

Limitations

- Reimbursement amount is based on a fixed fee scale determined by this office.
- Financial aid is limited to any number of sessions within 180 days of the first charged visit (up to the allowable recovery amount including other benefits) or 20 sessions scheduled as needed for resurfacing trauma, whichever is greater.
- This office pays the outstanding balance from bills not fully covered by existing medical insurance; if a victim has private or public medical insurance, bills must first be filed with applicable companies/ carriers before submission to this office for possible payment.

SOVA Physician's Disability Report - Lost Wages Rev. 6/08

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An application for assistance has been filed with our office for the crime victim listed below.
Please complete this form and return it to us as soon as possible; a fax is acceptable.

Full name of injured patient _____

Social Security No. _____ /_____ / _____ Date of Birth _____ /_____ / _____

Date the patient was first seen by you _____ /_____ / _____

Diagnosis:_____

_____

Briefly describe extent and location of injuries: _____

_____

Did the patient sustain any disability? Yes No (Please circle one.)

If yes, is the disability solely a result of this injury? Yes No (Please circle one.)

Please explain:_____

_____

Patient will be totally unable to work from _____/_____/_____ through _____/_____/_____

Patient will be partially unable to work from _____/_____/_____ through _____/_____/_____

Has the patient been discharged from your care? Yes No (Please circle one.)

Has payment been filed with any of the following?

Medicaid	Yes	No	Policy #_____
Medicare	Yes	No	Policy #_____
Workers' Compensation	Yes	No	
Other insurance or program	Yes	No	Company or Agency _____
			Address _____
			_____

Type or print physician's name _____ Phone (_____)_____

Signature of physician_____ Date _____ /_____ / ____

Address of physician_____

SOVA Employer's Report - Lost Wages / Support Rev. 6/08

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SOVA Claimant/Applicant filing for benefits *(print full name)* _____

Job Type _____ Social Security No. _____ /_____ / _____ Date of Birth _____ /_____ / _____

Employer: An application for assistance has been filed for the person listed above.
Please complete this form and return it to* SOVA *as soon as possible; a fax is acceptable.

Date the above person was first employed by you _____ /_____ / _____

Date he/she was first absent due to crime related injuries _____ /_____ / _____

Date he/she returned to work part time, if applicable _____ /_____ / _____

Date he/she returned to work full time _____ /_____ / _____

Date he/she was terminated, if no longer employed by you _____ /_____ / _____

Insurance Type and Policy No.

Health/Medical # _____ **Disability # _____**

Was this employee compensated for time absent from work? _____ ***If so, how much?*** _____

Daily Work Schedule: from _____ ***am/pm to*** _____ ***am/pm***

Average work hours per week _____ ***Average overtime per week*** _____

Average hourly wage _____ ***Overtime hourly wage*** _____

Gross salary per week _____ ***Average commissions per week*** _____

Employer _____ Address _____ Phone No. (____)_____

Person Completing Form *(print)* _____ ***Signature***_____

Title _____ ***Date*** _____ ***Comments?***_____

**Further documentation may be required to receive lost wages/support, i.e., W-2, pay stubs, or tax returns. Wages will be offset by other sources such as annual or sick leave, social security or disability.